

FILED MAR 15 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 5877

BIRTH NO. 124		REG. DIST. NO. 316		PRIMARY REG. DIST. NO. 3061		Registrar's No. 80	
1. PLACE OF DEATH a. COUNTY <i>St. Francois</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <i>Mo</i> b. COUNTY <i>St. Francois</i>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>Flat River, Mo.</i>		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <i>Flat River, Mo.</i>		d. STREET ADDRESS (If rural, give location) <i>500 Adams St.</i>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <i>500 Adams St. Home address.</i>							
3. NAME OF DECEASED (Type or Print)		a. (First) <i>Sylvester</i>		b. (Middle) <i>Lee</i>		c. (Last) <i>Willard</i>	
4. DATE OF DEATH		(Month) <i>March</i>		(Day) <i>3</i>		(Year) <i>1949</i>	
5. SEX <i>male</i>		6. COLOR OR RACE <i>White-Cauc.</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>		8. DATE OF BIRTH <i>February 22-1867</i>	
9. AGE (In years last birthday) <i>87</i>		10. UNDER 1 YEAR Months <i>0</i> Days <i>11</i>		11. UNDER 1 YEAR Hours <i></i> Min. <i></i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Drill operator - R. 18 yrs.</i>		10b. KIND OF BUSINESS, OR INDUSTRY <i>St. Joseph Lead Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Yorkville, North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13a. FATHER'S NAME <i>Mr. Lemus Willard</i>		13b. MOTHER'S MAIDEN NAME <i>Martha Rhodes</i>		14. NAME OF HUSBAND OR WIFE <i>Sarah Frances Willard</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT'S SIGNATURE OR NAME <i>Mrs. Sarah Frances Willard</i>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION 1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Coronary Thrombosis</i> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Arteriosclerotic cardiovascular</i> DUE TO (c) <i>disease with acute decompensation</i> 2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Chronic</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <i>4201</i>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Jan 3</i> 1949, to <i>March 3</i> 1949, that I last saw the deceased alive on <i>March 2</i> 1949, and that death occurred at <i>1:25</i> p.m., from the causes and on the date stated above.							
23a. SIGNATURE <i>J. L. Foster M.D.</i>				23b. ADDRESS <i>Desloge Mo.</i>		23c. DATE SIGNED <i>3-5-49</i>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24b. DATE <i>March 4 - 1949</i>		24c. NAME OF CEMETERY OR CREMATORY <i>Park View Cemetery</i>		24d. LOCATION (City, town, or county) (State) <i>Jarvisburg Mo.</i>	
DATE REC'D BY LOCAL REG. <i>Mar. 9, 1949</i>		REGISTRAR'S SIGNATURE <i>Esther Rudolph</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Alvin W. Hood</i>			
				ADDRESS <i>303 Crane St. Flat River, Mo.</i>			

(Licensed Embalmers' Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

Health Officer No. 4

File Number 349-35

3-14-49

JUN 15 1950

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

Student Embalmer No.

working under my personal supervision.

Student .....  
Student Embalmer

Signed Alvin W. Hood

Licensed Embalmer No. 2780

P. O. Address 303 Crane St. Flint River

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.